Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
HIGHLANDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-0038-01

MFDR Date Received
SEPTEMBER 2, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this case, the Carrier did not make payment according to the Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula. The sum of the Medicare facility specific reimbursement amount shall be multiplied by 130%, due to the fact that the provider did include certified implant invoices with the bill. Therefore, the Provider does request separate reimbursement for implantables."

Amount in Dispute: $4,481.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Vista Hospital billed the insurance carrier $63,808.09 for the outpatient procedure, $8,350 of which was for implants. As stated in Vista Hospital's letter included with the medical dispute, Vista Hospital requested separate reimbursement for the implants. Thus, the bill was reviewed under 28 TAC Sections 134.403(f)(1)(B) and 134.403(g)... The insurance carrier reviewed the bill and payment of $10,020.27 was made… With regard to the implantables, Vista Hospital charged the carrier $8,350.00 for 5 items of Anchor Panalock/Lupi (see document 25). According to the invoice (document 34), the cost of each LUPINE BR W/ORTHCRD was $316.35, for a total of $1,581.75 for five units. The carrier reimbursed Vista Hospital $1,739.93 ($1,581.75 x 10%)."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Dr. #104, Austin, TX 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2010	Outpatient Hospital Services	$4,481.99	$4,481.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 17, 2010 and July 8, 2010
   - W1 – W/C State Fee Schedule adjustment.
   - 57 – Payment denied/reduced because documentation does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
   - 97 – Payment is included in the allowance for another service or procedure for this outpatient hospital procedure. Unbundling of institutional services.
   - W4 – No supplemental reimbursement after review of request for reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code A4649 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $3.39. 125% of this amount is $4.24. The recommended payment is $4.24.

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.

- Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0052, which, per OPPS Addendum A, has a payment rate of $5,975.68. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,585.41. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $3,488.96. The non-labor related portion is 40% of the APC rate or $2,390.27. The sum of the labor and non-labor related amounts is $5,879.23. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.339. This ratio multiplied by the billed charge of $1,714.80 yields a cost of $581.32. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $5,879.23 divided by the sum of all APC payments is 65.57%. The sum of all packaged costs is $17,042.79. The allocated portion of packaged costs is $11,175.35. This amount added to the service cost yields a total cost of $11,756.67. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,468.01. 50% of this amount is $734.01. The total APC payment for this service, including outliers and any multiple procedure discount, is $6,613.24. This amount multiplied by 130% yields a MAR of $8,597.21.

- Procedure code 29889 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0052, which, per OPPS Addendum A, has a payment rate of $5,975.68. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,585.41. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $3,488.96. The non-labor related portion is 40% of the APC rate or $2,390.27. The sum of the labor and non-labor related amounts is $5,879.23. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.339. This ratio multiplied by the billed charge of $1,714.80 yields a cost of $581.32. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $2,939.62 divided by the sum of all APC payments is 32.79%. The sum of all packaged costs is $17,042.79. The allocated portion of packaged costs is $5,587.68. This amount added to the service cost yields a total cost of $6,168.99. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,024.67. 50% of this amount is $512.33. The total APC payment for this service, including outliers and any multiple procedure discount, is $3,451.95. This amount multiplied by 130% yields a MAR of $4,487.53.

- Per Medicare policy, procedure code 29876 is included in, or mutually exclusive to, another code billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.

- Per Medicare policy, procedure code 29883 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.

- Procedure code 20926 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0135, which, per OPPS Addendum A, has a payment rate of $299.19. This amount multiplied by 60% yields an unadjusted labor-related amount of $179.51. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $174.69. The non-labor related portion is 40% of the APC rate or $119.68. The sum of the labor and non-labor related amounts is $294.36. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service,

including outliers and any multiple procedure discount, is $147.18. This amount multiplied by 130% yields a MAR of $191.33.

- Per Medicare policy, procedure code 94762 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include 5 items identified on the itemized statement as "ANCHOR PANALOCK/LUPI" and identified on the invoice as "LUPINE BR W/ORTHCRD" at $316.35 per unit. The total net invoice amount (exclusive of rebates and discounts) is $1,581.75. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $158.18. The total recommended reimbursement amount for the implantable items is $1,739.93.

4. The total recommended payment for the services in dispute is $15,024.00. This amount less the amount previously paid by the insurance carrier of $10,020.27 leaves an amount due to the requestor of $5,003.73. The requestor is seeking $4,481.99. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,481.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,481.99, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 24, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.